

A New Tomorrow Behavioral Health Services

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ADULT INTAKE PACKET

General Information:

Date: _____

Patient's Full Name: _____ Sex: _____

Gender Identity (Optional): _____ Sexual Preference (Optional): _____

Date of Birth: _____ Social Security Number: _____ Age: _____

Address: _____

Street

City/State

Zip

Home Phone: _____ Ok to leave message? Yes No

Cell Phone: _____ Ok to leave message? Yes No

Work Phone: _____ Ok to leave message? Yes No

Email: _____

Spiritual / Cultural Factors (Optional):

Please Describe Your Social Interactions:

Family Information:

Marital Status (circle one)

Single Living with Partner Married Separated Divorced Widowed

Rate quality of present relationship / marriage (if applicable):

___ very good ___ good ___ fair ___ poor ___ very poor

Your Occupation: _____

Occupation of Spouse / Partner: _____

Education Level: _____

Children and Ages:

If divorced, what are the custody arrangements?

Who currently resides in your home?

Has anyone in the birth family had any of the following psychological disorders? Check all that apply and list who (self, mother, father, sibling, child):

<u>Yes</u>	<u>Condition</u>	<u>Family Member</u>
___	Intellectual Disability	_____
___	Speech or Communication Disorder	_____
___	Attention Deficit/Hyperactivity/Impulsivity	_____
___	Learning Problems/Developmental Disorder	_____
___	Autism Spectrum/Asperger's Disorder	_____

- ___ Sleep Disorders _____
 - ___ Obsessive-Compulsive Disorder _____
 - ___ Phobias _____
 - ___ Anxiety _____
 - ___ Depression _____
 - ___ Manic-Depression/Bipolar Disorder _____
 - ___ Suicide Attempts/Suicide _____
 - ___ Schizophrenia or other psychosis _____
 - ___ Alcohol/Substance Abuse _____
 - ___ Seizures or other neurological disorder _____
 - ___ Genetic Disorder (e.g., Down Syndrome, Fragile X) _____
- Other: _____

Medical Information:

Primary Care Physician: _____

When was your last physical exam? Any relevant findings?

Are there any other physicians you see on a regular basis?

Describe any medical conditions that you have been diagnosed as having and any medical procedures you have had (surgeries, etc.).

List any medications (and the dosages) you take regularly. Include your prescriptions, over the counter medicines, vitamins, and supplements.

Client Psychiatric History:

Has the client had prior mental health counseling? ___ yes ___ no

Describe previous mental health services you have received (evaluations and therapy). Include any diagnosis and length of treatment.

Is there a history of mental illness in the family? ___ yes ___ no

Explain:

Presenting Concern:

Present psychological difficulties – please check any that apply to you at this time.

- ___ Generalized Anxiety (across many situations)
- ___ Specific fears/phobias (list): _____
- ___ Panic attacks
- ___ Social Anxiety
- ___ Obsessive thinking or compulsive behaviors
- ___ Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)
- ___ Sadness or Depression
- ___ Emotionally overwhelmed
- ___ Frequent crying
- ___ Loss of energy
- ___ Loss of pleasure in life
- ___ Self-injurious/Self-harm behavior
- ___ Thoughts of suicide
- ___ Problems with eating
- ___ Problems falling asleep

- ___ Problems sleeping through the night (middle of the night waking or early morning waking)
- ___ Trouble waking up
- ___ Fatigue/tiredness during the day
- ___ Nightmares
- ___ Problems with attention or concentration
- ___ Racing thoughts
- ___ Problems making or keeping friends
- ___ Problems controlling anger
- ___ Relationship/Marriage problems
- ___ Problems with intimacy
- ___ Problems with job
- ___ History of abuse (emotional, physical, sexual)
- ___ Alcohol/drug use/abuse
- ___ Financial problems
- ___ Legal situation

Other: _____

Legal History

Have you ever filed or been involved in any litigation? Please explain

Is there anything else we should know about you that was not covered by this form?

Insurance:

Primary Insurance: _____ ID Number: _____

Name of Insured: _____ Insured's Date of Birth: _____

Insured Address: _____ Phone: _____

Secondary Insurance: _____ ID Number: _____

Name of Insured: _____ Insured's Date of Birth: _____

Insured Address: _____ Phone: _____

Responsible Party:

Name: _____ Relationship: _____

Address: _____

Primary Phone: _____ Alternate Phone: _____

I authorize this provider to release any information, including diagnosis, treatment plans / records to third party payers and / or health practitioners. I authorize and request that my insurance company (if applicable) pay directly to the provider or medical benefits that are, otherwise, payable to me. I understand that my medical insurance may pay less than the actual bill for service or may not cover certain treatment.

I hereby certify that the foregoing information is accurate and complete and that in consideration of treatment and services rendered to me or my dependents by this medical office. I accept responsibility and understand that I am responsible for the charges and fees that are due at the time service is provided, unless I make arrangements in advance.

Signature: _____ Date: _____